MARYLAND
DUALS CARE DELIVERY WORKGROUP

WEB-BASED EDUCATIONAL SESSION

FEBRUARY 18, 2016 | 9:30-11 AM

AGENDA

- Vision and goals of project
- Purpose of Workgroup
- Maryland Landscape
  - All-Payer Model
  - CRISP
- Discussion

MARYLAND'S STATE INNOVATION MODEL

- DHMH was awarded a CMS State Innovation Model design grant Dec 2014.
  - This grant is funding the State to engage in tasks related to the development of a new model, one similar to an Integrated Delivery Network (IDN) or an Accountable Care Organization (ACO), for dual eligibles.
- The State is working on a single transformation effort with multiple related projects rather than multiple initiatives each in a silo.
- The focus on dual eligibles reflects that new models of care for these beneficiaries had not yet been identified or designed as part of larger reform efforts.
- Maryland is interested in assessing the development of a strategy to integrate care delivery for Maryland's dually-eligible.
  - It is in the State's and duals' interest to design one strategy for the current FFS duals instead of piloting several approaches

SIM GRANT GOALS

- The SIM grant is multifaceted, and includes:
  - Dual eligible strategy development
  - Support for CRISP's efforts to expand connectivity among additional providers
  - Development of care plans and predictive modeling tools to help with care coordination for high needs patients
  - Design of the Plan for Improving Population Health—a strategy that sets population health goals for the All-Payer Model
- All aspects of the SIM grant support one another and provide additional groundwork for transformation in the All-Payer Model

MARYLAND'S ALL-PAYER MODEL

- Maryland has been engaged in delivery system innovation, most recently with the implementation of the All-Payer Model beginning January 2014.
- The SIM grant complements the All-Payer Model by allowing the state to focus on:
  - The challenges associated with serving the high-cost and largely-unmanaged dual eligible population;
  - The work of the state-designated Health Information Exchange (HIE), CRISP, to expand connectivity among providers;
  - The development of a population health strategy; and
  - High-needs individuals across the state through the development of care plans and predictive modeling to support care coordination.

VISION AND GOALS OF THE PROJECT

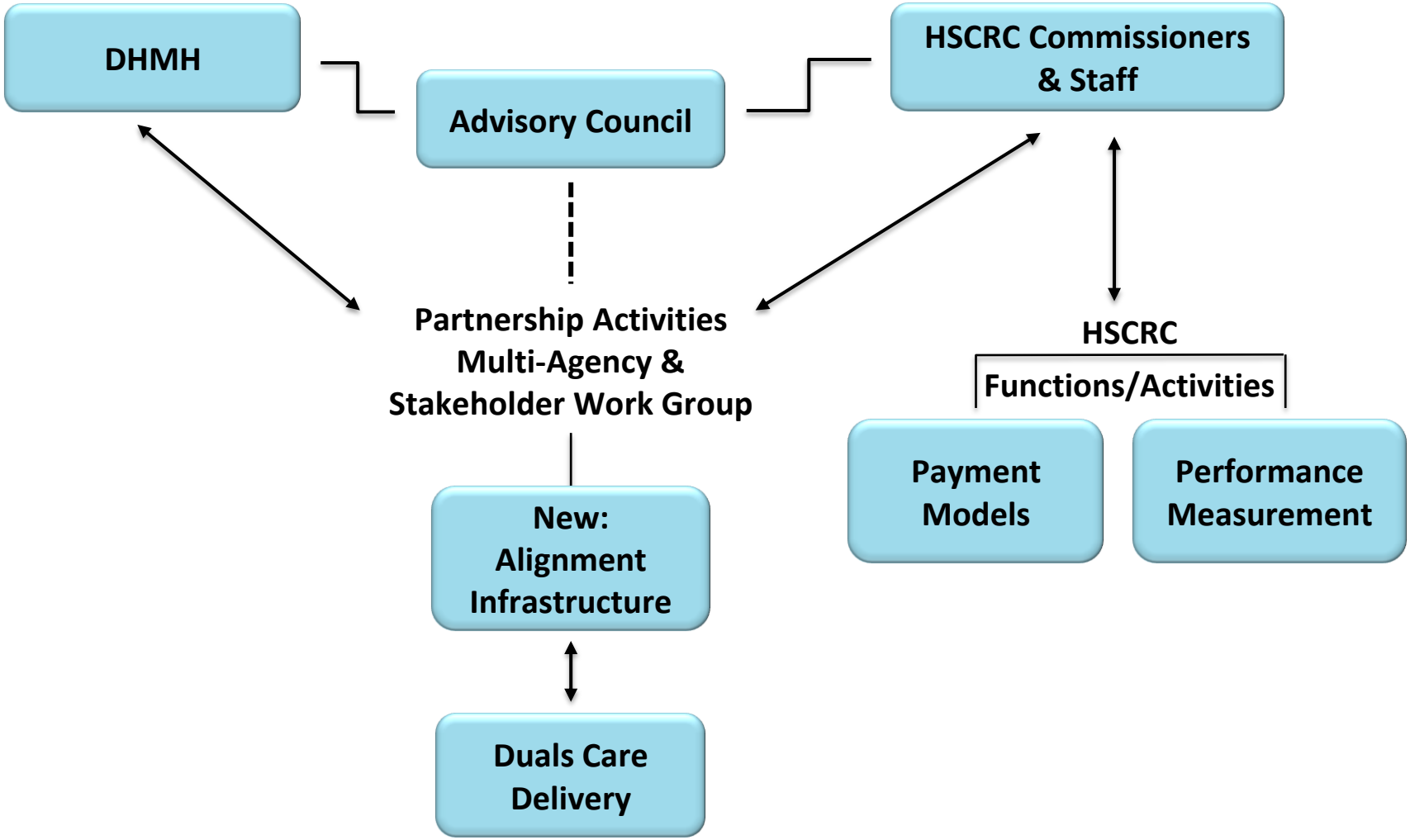
DHMH's focus on dual eligibles is based on the consensus that was achieved through the Advisory Council and multiple workgroups that full duals should be a top priority.

- The SIM project is integrated into the planning efforts already underway as part of the All-Payer Model.
- Maryland stakeholders have identified dual eligibles as a population with substantial health and social support needs who are largely unmanaged in the current delivery system.
- The focus on duals reflects the fact that new models of care for these beneficiaries have not been systematically identified.

WORKGROUP MEMBERS

- Alzheimer Association, Maryland
- Amerigroup
- CareFirst BlueCross BlueShield
- CRISP
- Dorchester County Addictions Program - National Council on Alcoholism and Drug Dependence
- Erickson Living
- Health Facilities Association of Maryland
- Johns Hopkins HealthCare
- Maryland Department of Aging
- Maryland Health Care for All Coalition
- Maryland Hospital Association
- Maryland Learning Collaborative
- MedChi
- MedStar Health
- Mental Health Association of Maryland (MHAMD)
- Mid-Atlantic Association of Community Health Centers
- Mid-Atlantic Healthcare
- Mosaic Inc.
- Schwartz, Metz & Wise
- Talbot County
- The Coordinating Center
- Towson University
- University of Maryland
- Way Station Inc./
  Sheppard Pratt Health Systems

PROPOSED STAKEHOLDER ENGAGEMENT STRUCTURE



VISION AND GOALS, CONTINUED

- DHMH selected EBG Advisors, through a competitive procurement, to work with and track the developments of the HSCRC and their contractors—as well as our partners at CMMI—as the State moves forward with the Phase 2 approach to the All-Payer Model through CY 2016.
- DHMH and EBG Advisors will continue to develop a Duals Care Delivery strategy in collaboration with other state and federal partners by inviting them into the stakeholder process and continuing to hold joint leadership meetings. The work will include:
  - *The governance model.*
  - *The beneficiary attribution process.*
  - *The provider attribution/alignment process.*
  - *Accounting for total cost of care.*
  - *Development of quality metrics and incentives.*

WORKGROUP'S PURPOSE

The purpose of the Duals Care Delivery Workgroup is to facilitate multi-stakeholder discussions regarding efficient and effective implementation of the dual eligible program design that supports CMMI's goals and DHMH's goals. They are:

Improve the patient experience, improve the health of populations, and reduce the growth in per capita costs of health care

- Alignment: Promote value-based payment
- Care Delivery: Increase integration and coordination
- Health Information Exchange and Tools: Support providers

MARYLAND LANDSCAPE

ALIGNMENT WITH CURRENT INITIATIVES

HEALTH SERVICES COST REVIEW COMMISSION (HSCRC)

- Donna Kinzer, Executive Director

Maryland's All-Payer Model: Patient-Centered Delivery System Transformation

February 18, 2016

HSCRC
Health Services Cost Review Commission

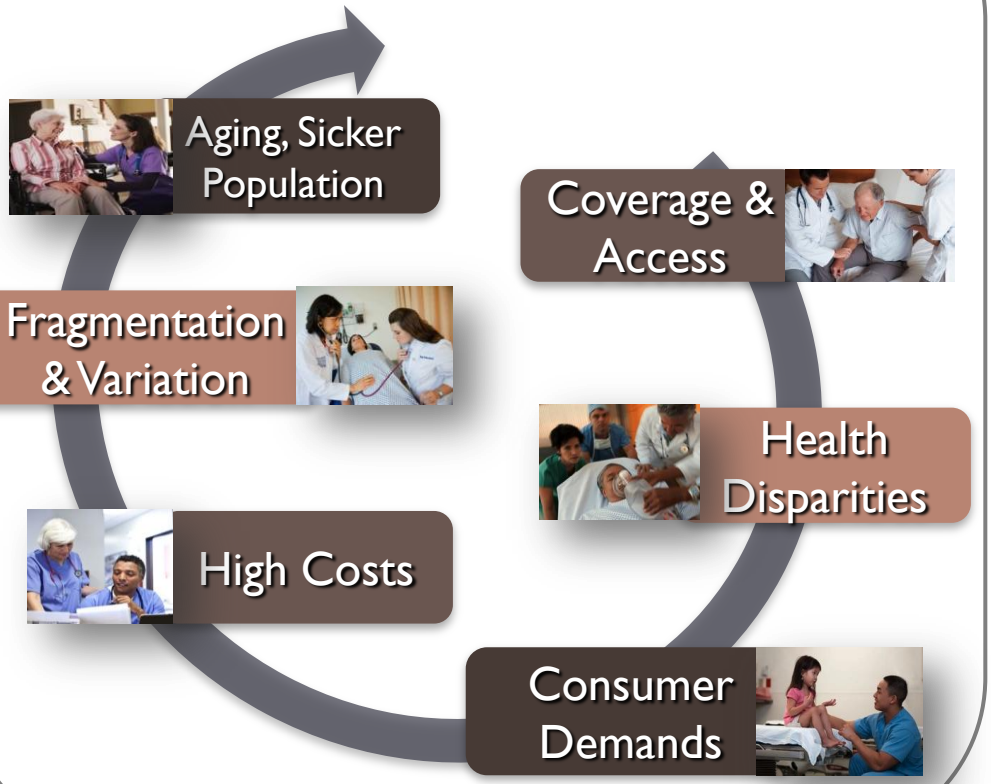
Overview

- The Evolving Health Care Landscape & Maryland's All-Payer Model
- All-Payer Model Implementation
- Person-Centered Delivery System Transformation

The Evolving Health Care Landscape & Maryland's All-Payer Model

Context: Health Care System Challenges

Current System



More Ahead. . .

- Changes in Demographics and Expenditures

Year	Age 65+
2010	40 million
2020	55 million
2030	72 million

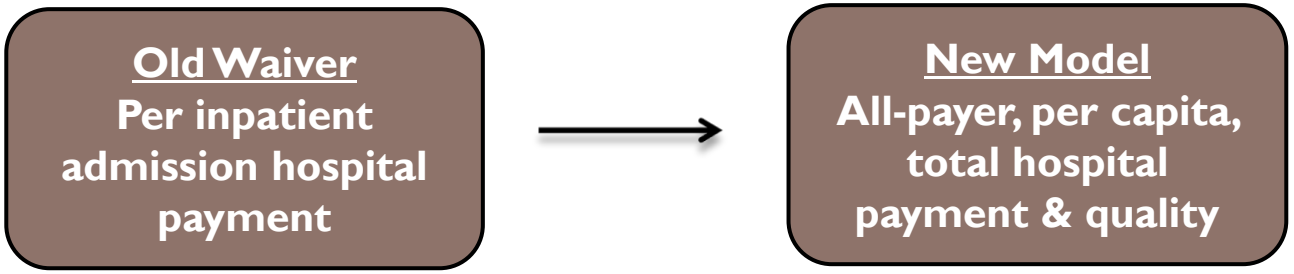
- Federal Budget & Health Care Spending
  - More Entitlements, Fewer Contributors

Health Services Cost Review Commission (HSCRC)

- Leads implementation of Maryland's All-Payer Model
- Oversees hospital rate regulation in Maryland with broad statutory authority
- Responsible for all-payer rate setting in Maryland, which provides considerable value to patients, hospital and the State
  - A Medicare waiver, allowing HSCRC to set hospital rates for Medicare, was granted in 1977 and renewed under a different approach in 2014
  - State Medicaid plan pays HSCRC rates
  - State law requires health insurers, managed care organizations, and others to pay HSCRC rates
  - Limits cost shifting--all payers pay their fair share, including funds for uncompensated care and graduate medical education

Unique New Model: Maryland's All-Payer Model

- Maryland is implementing an All-Payer Model for hospital payment
  - Approved by Center for Medicare and Medicaid Innovation (CMMI) effective January 1, 2014 for 5 years
  - Modernizes Maryland's Medicare waiver and unique all-payer hospital rate system



- Key provisions of the new Model:
  - Hospital per capita revenue growth ceiling of 3.58% per year, with savings of at least $330 million to Medicare over 5 years
  - Patient and population centered-measures to promote care improvement
  - Payment transformation away from fee-for-service for hospital services
  - Proposal covering all health spending due at the end of Year 3 for 2019 and beyond

All-Payer Model Implementation

Maryland Model: Implementation in Year 1 (2014)

Year 1 Approach

Initiate payment reform (Hospital global budgets and value-based performance requirements)

Focus policies on reducing potentially avoidable utilization through care improvements

Engage stakeholders

Build regulatory infrastructure

Maryland's Current Situation & Future Focus

Years 2-3 Focus (Now)

Work on clinical improvement, care coordination, integration planning, and infrastructure development

Partner across hospitals, physicians and other providers, post-acute and long-term care, and communities to plan and implement changes to care delivery

Alignment planning and development

Years 4-5 Focus

Implement changes, and improve care coordination and chronic care

Focus on alignment models

Engage patients, families, and communities

Focus on payment model progression, total cost of care and extending the model

2014-2015 All-Payer Model Results

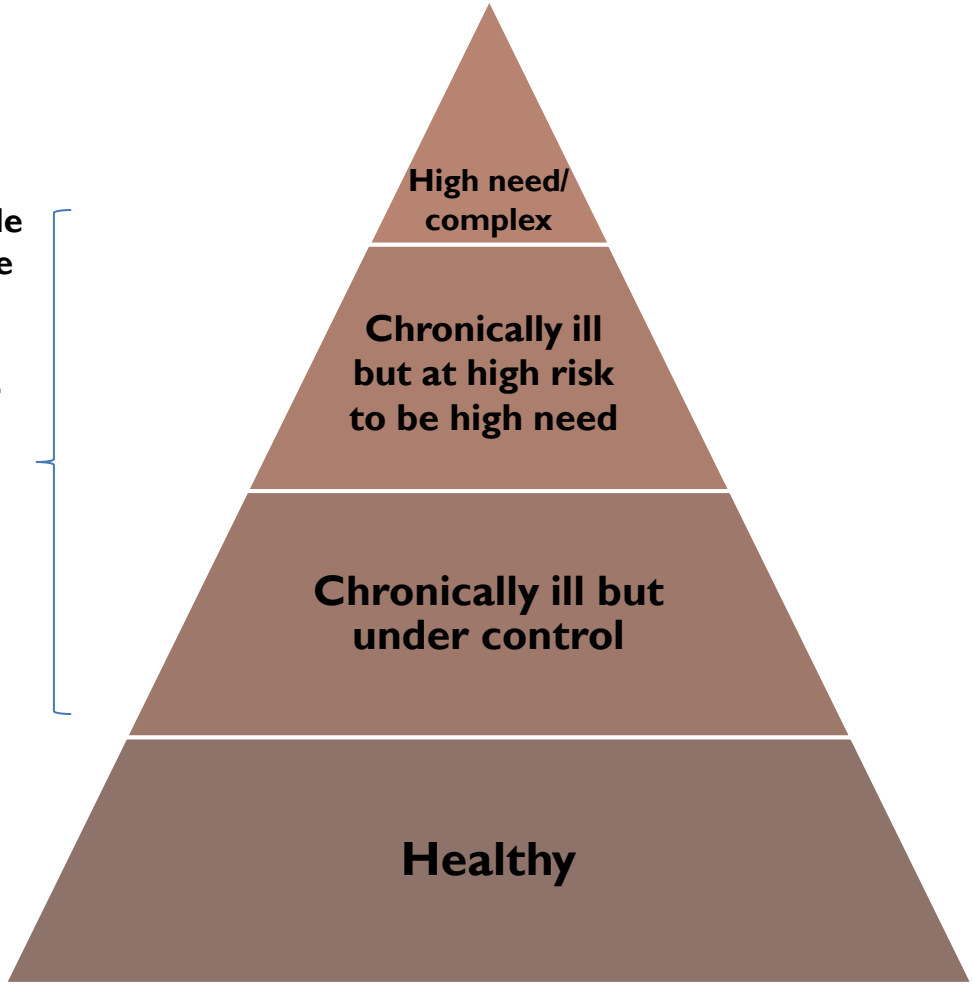
- All hospitals adopted global budgets, encompassing ~95% of revenues, ahead of schedule
- All Payer hospital revenue growth was contained to 1.47% per capita, compared to the 3.58% per capita ceiling; Medicare hospital savings of $116 million were achieved toward the $330 million five year requirement.
- Quality measures for hospital acquired conditions were achieved and readmissions were reduced.
- Overall hospital volumes have been contained in 2015. In contrast, national estimates show substantial all payer hospital volume growth.

Person-Centered Delivery System Transformation

Deliver Care Based on Person-Centered Needs

B

Address modifiable risks and integrate and coordinate care, develop advanced patient-centered medical homes, primary care disease management, public health, and social service supports, and integrated specialty care



A

Care plans, support services, case management, new models, and other interventions for individuals with significant demands on health care resources

C

Promote and maintain health (e.g. via patient-centered medical homes)

Stakeholder-Driven Strategy for Maryland

Aligning common interests and transforming the delivery system are key to sustainability and to meeting Maryland's goals

Focus Areas	Description
Care Delivery	• Encourage integration and coordination of clinical care • Support provider-driven plans for improving care for complex patients and improving chronic care • Support enhancement of primary care practices and models • Promote consumer engagement through shared decision-making and state & local outreach efforts
Health Information Exchange and Tools	• Enhance capabilities of CRISP (Maryland's Health Information Exchange) to support providers, ACOs, and payers • Connect providers in addition to hospitals (physicians, long-term care, etc.) • Develop shared tools (e.g. common care profiles) • Bring additional electronic health information to the point of care
Alignment	• Promote value-based payment systems, focused on improved outcomes • Develop alternative payment models and other transformation opportunities • Build on private payer medical home models, Accountable Care Organizations formed by providers, and emerging Medicare Advantage plans

The Next Steps Needed for Maryland's Transformation

- Develop approach to care transformation that improves care and also reduces avoidable hospitalizations
- Fully implement care coordination to scale, first for complex and high needs patients
  - Intense focus on Medicare and dual eligible, where supports are immature
- Organize and engage primary care, long-term care, and other providers in care coordination and chronic care management
  - Intense focus on Medicare, where models do not exist or are immature, in Maryland
  - Build on growing PCMH and ACO models, global budgets, and Medicare and Chronic Care Management fees
- Develop financial alignment programs between hospital and non-hospital providers, and get data and waivers needed for implementation
- Optimize acute/post-acute
- Engage other providers

Thank you for the opportunity to work together to improve care in Maryland

Questions?

MARYLAND

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP)

- David Horrocks, President

CRISP

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS

CRISP Overview
Duals Workgroup Educational Session

February 2016

7160 Columbia Gateway Drive, Suite 230
Columbia, MD 21046
877.952.7477 | info@crisphealth.org
www.crisphealth.org

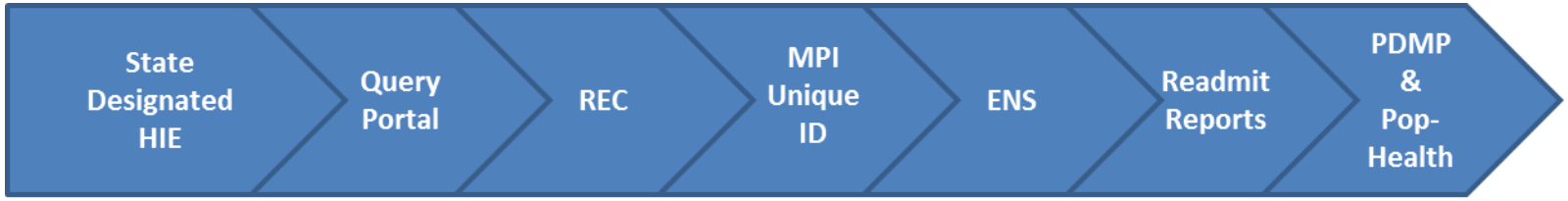
What is CRISP

CRISP is a regional health information exchange organization that services Maryland and the District of Columbia.

Our Guiding Principles

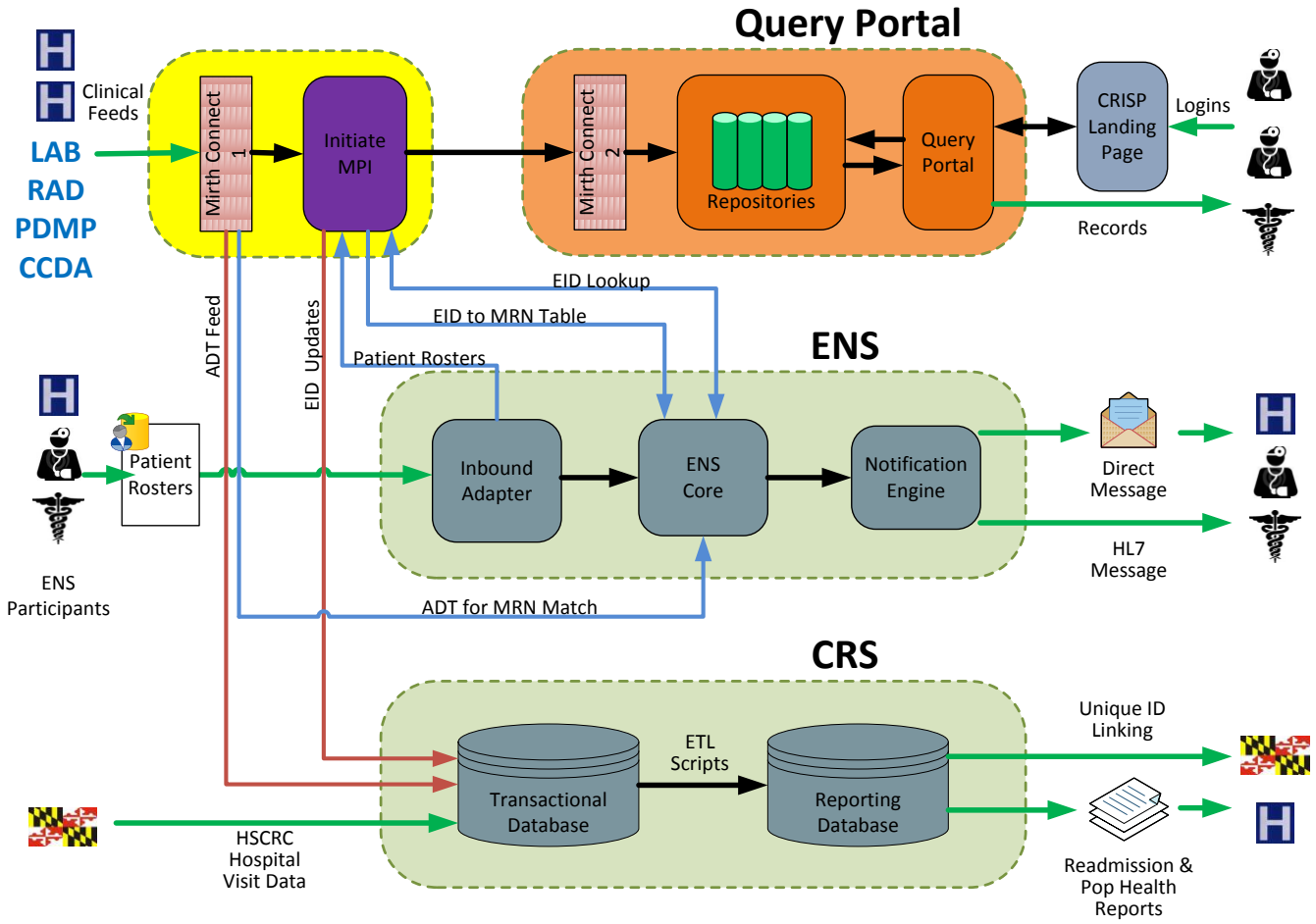
1. *Begin with a manageable scope and remain incremental.*
2. *Create opportunities to cooperate even while participating healthcare organizations still compete in other ways.*
3. *Affirm that competition and market-mechanisms spur innovation and improvement.*
4. *Promote and enable consumers' control over their own health information.*
5. *Use best practices and standards.*
6. *Serve our region's entire healthcare community.*

Annual Focus Areas and Theme Setting



Year (Fiscal)	Theme
2009 - 2010	Developing Infrastructure (Governance, People, Technology)
2010 - 2011	Creating Connectivity
2011 - 2012	Driving Utilization
2012 - 2013	Creating Value for Participants
2013 - 2014	Achieving Sustainability
2014 - 2015	Critical Infrastructure

Technical Overview



CRISP Services for Providers

1. Clinical Query Portal

- **Includes Maryland Prescription Drug Monitoring Program (PDMP)**
- Search for your patients' prior hospital and medication records
- Monitor the prescribing and dispensing of drugs that contain controlled dangerous substances

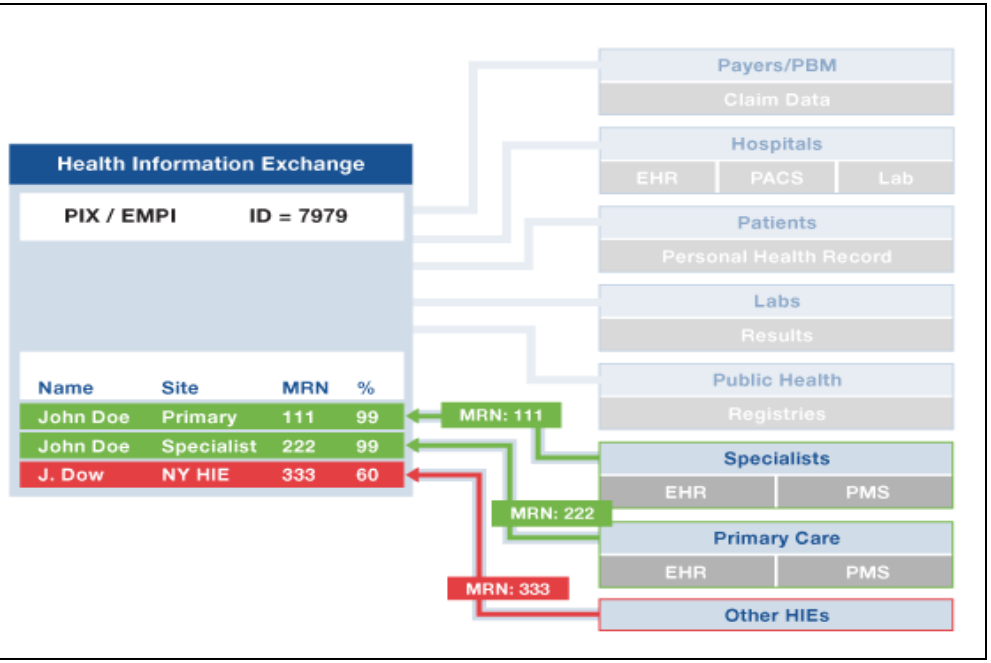
2. Encounter Notification Service (ENS)

- **Includes Direct Secure Messaging capabilities**
- Be notified in real time about patient visits to the hospital
- Use secure email instead of fax/phone for referrals and other care coordination

3. CRISP Reporting Services

- Use CRISP Data for patient identification, performance measurement and service coordination

Patient Identity Management

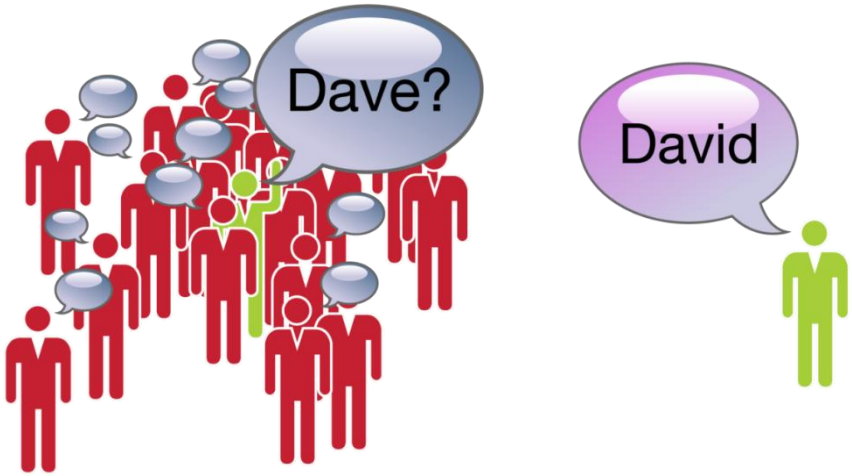


The Challenge:

Because no Unique Patient ID exists, CRISP must accurately and consistently link identities across multiple facilities to create a single view of a patient.

A near-zero tolerance of a false positive match rate with a low tolerance of a false negative match rate.

Effective Master Patient Indexing is a foundational concept to any population health oriented payment or delivery reform initiatives.



Query Portal

The query portal allows credentialed users to search the HIE for clinical data.

Users can search for patients using last name/DOB or the medical record number from your practice or a hospital.

The initial query returns information from the past 6 months and allows the user to query data as far back as June of 2012 (depending on when a given data sending went live).

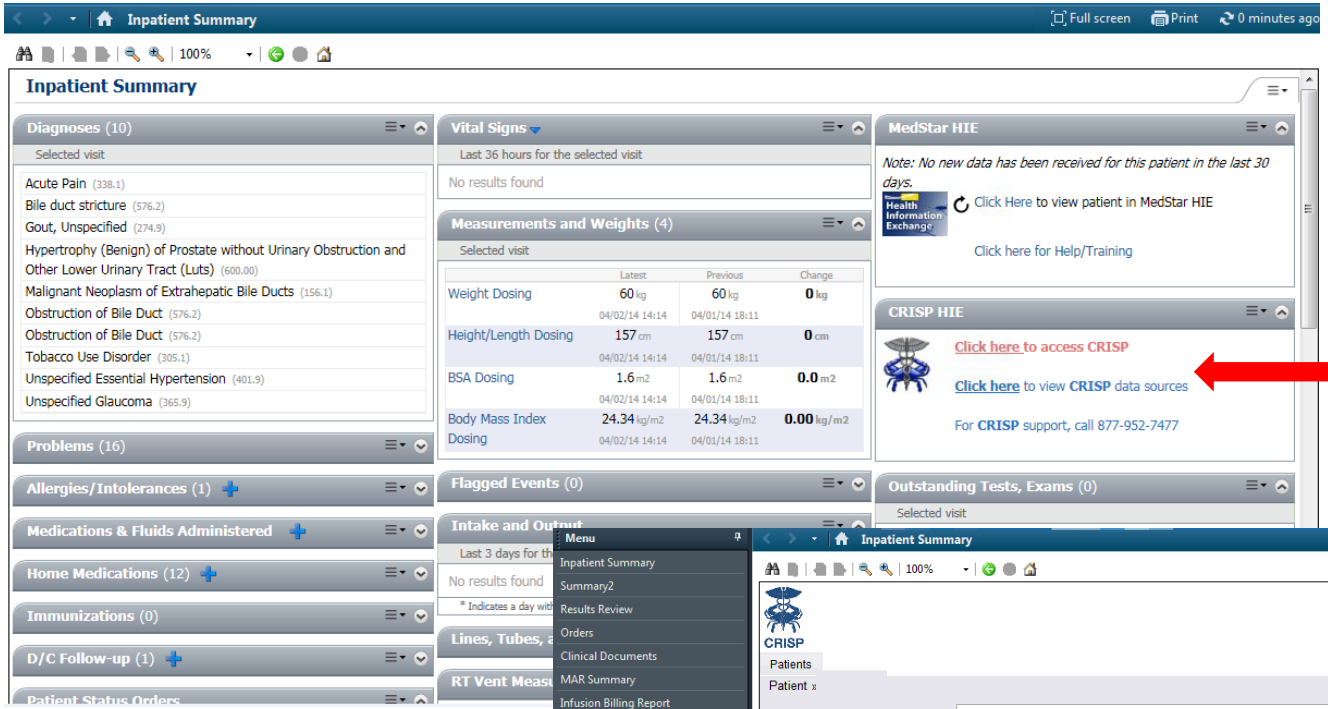
While a great tool, there are workflow challenges.

There are currently roughly 115,000 queries per month.

Types of data available:

- Patient demographics
- Lab results
- Radiology reports
- **PDMP Meds Data**
- Discharge summaries
- History and physicals
- Operative notes
- Consults

Clinical Query Portal - Single Sign-on



Single Sign-On (SSO) is an approach to enable faster and more efficient access to the query portal through the EHR.

By securely sending a local user's credentials and the current patient medical record number (or other demographics), CRISP can send the user directly to the patient summary screen.

Encounter Notification Service

CRISP currently receives information pertaining to **ER visits and inpatient admissions** in real-time:

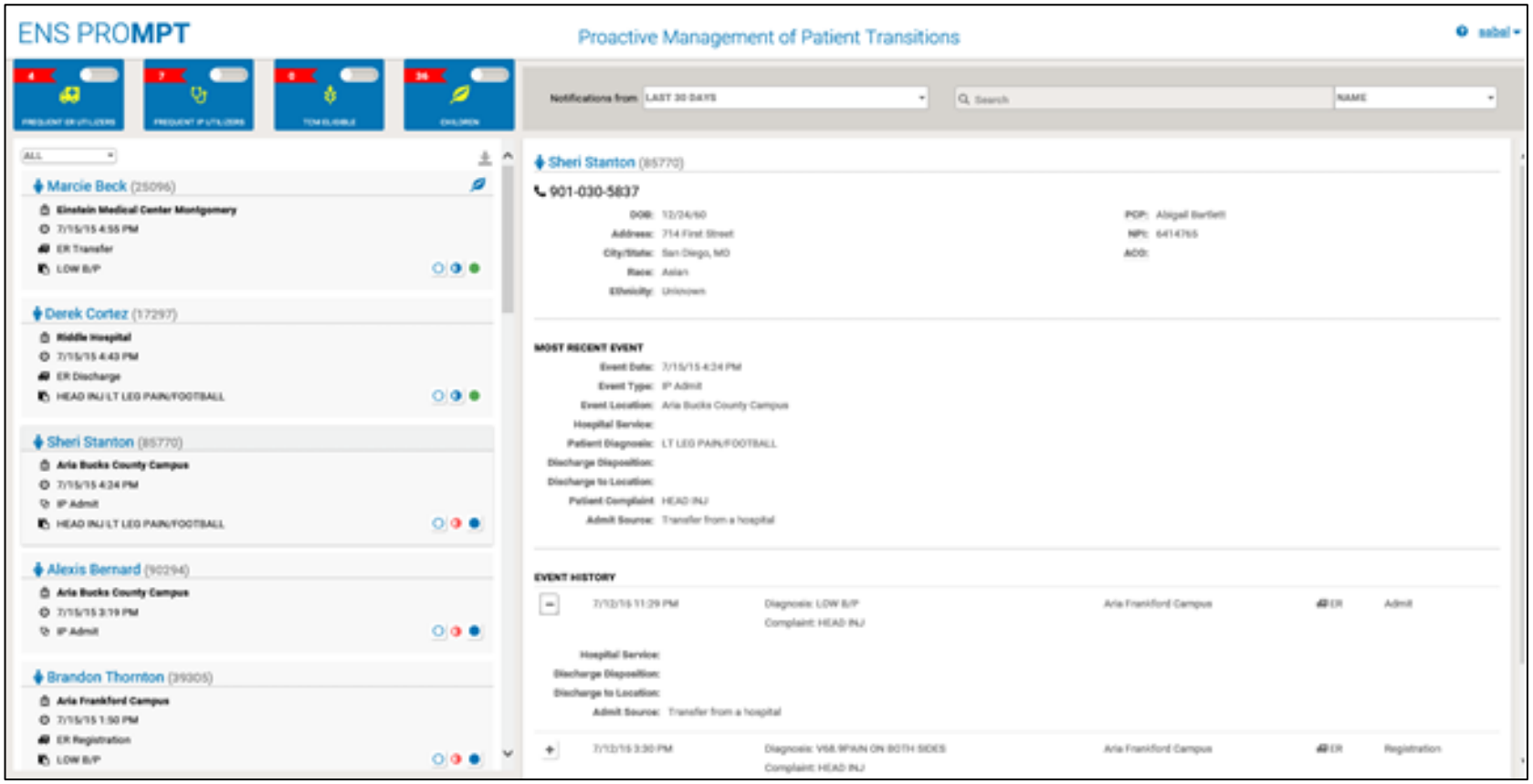
- All Maryland hospitals
- Most D.C. hospitals (1 remaining currently working through on-boarding)
- All Delaware hospitals and most Northern Virginia hospitals

Through ENS, CRISP has the ability to communicate this information, in the form of **real time hospitalization alerts** to PCPs, care coordinators, and others responsible for patient care.

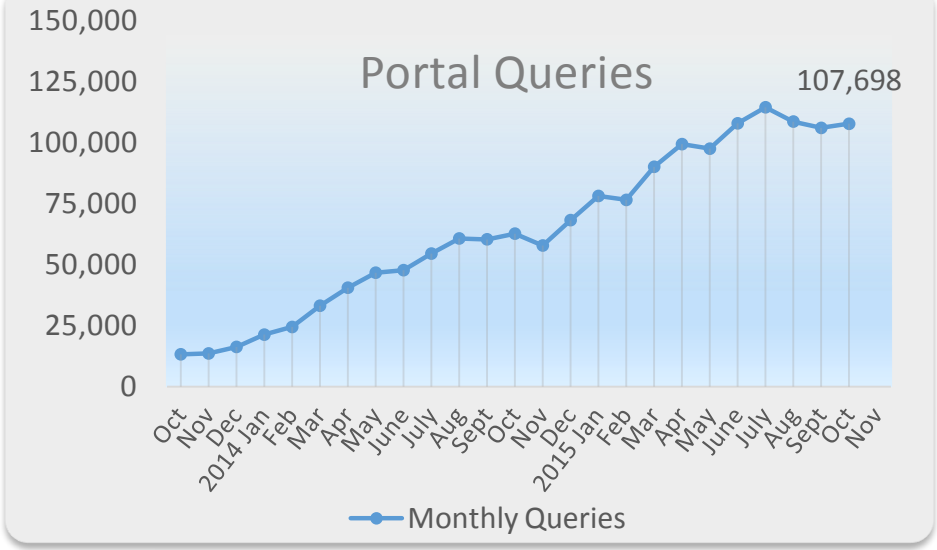
We are current routing roughly 700,000 notifications per month.

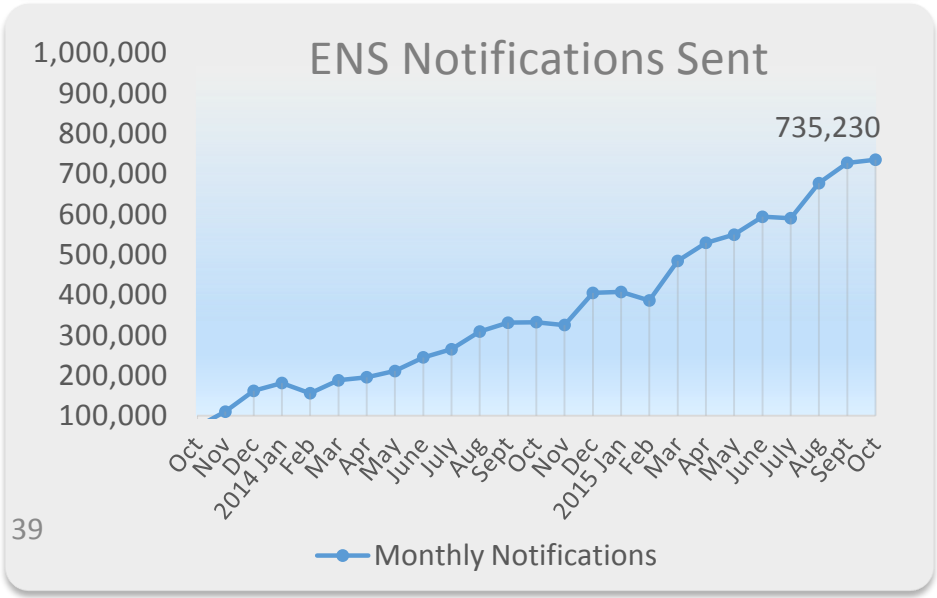
Roughly 30 hospitals are “auto-subscribing” so they can be alerted when one of their past discharges is being readmitted within 30 days.

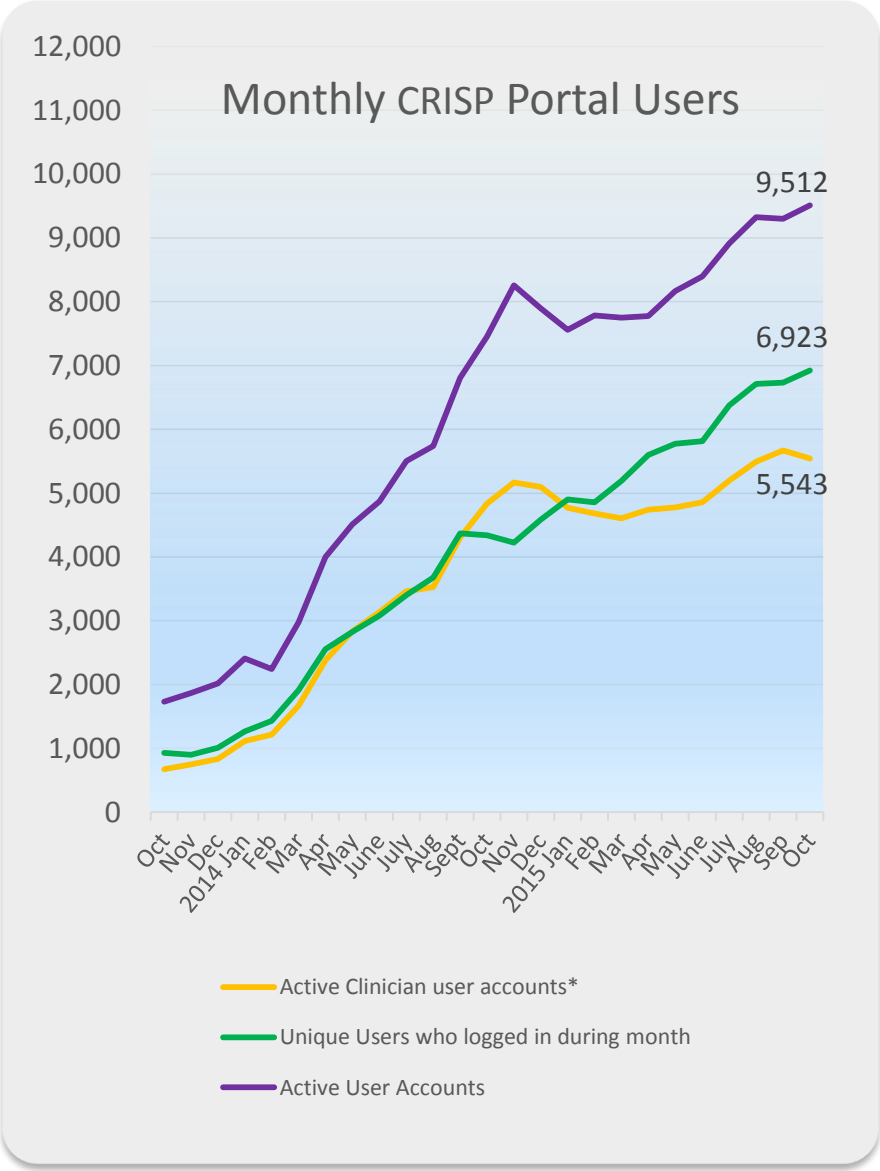
Additional ENS Access Points



CRISP Key Performance Indicators







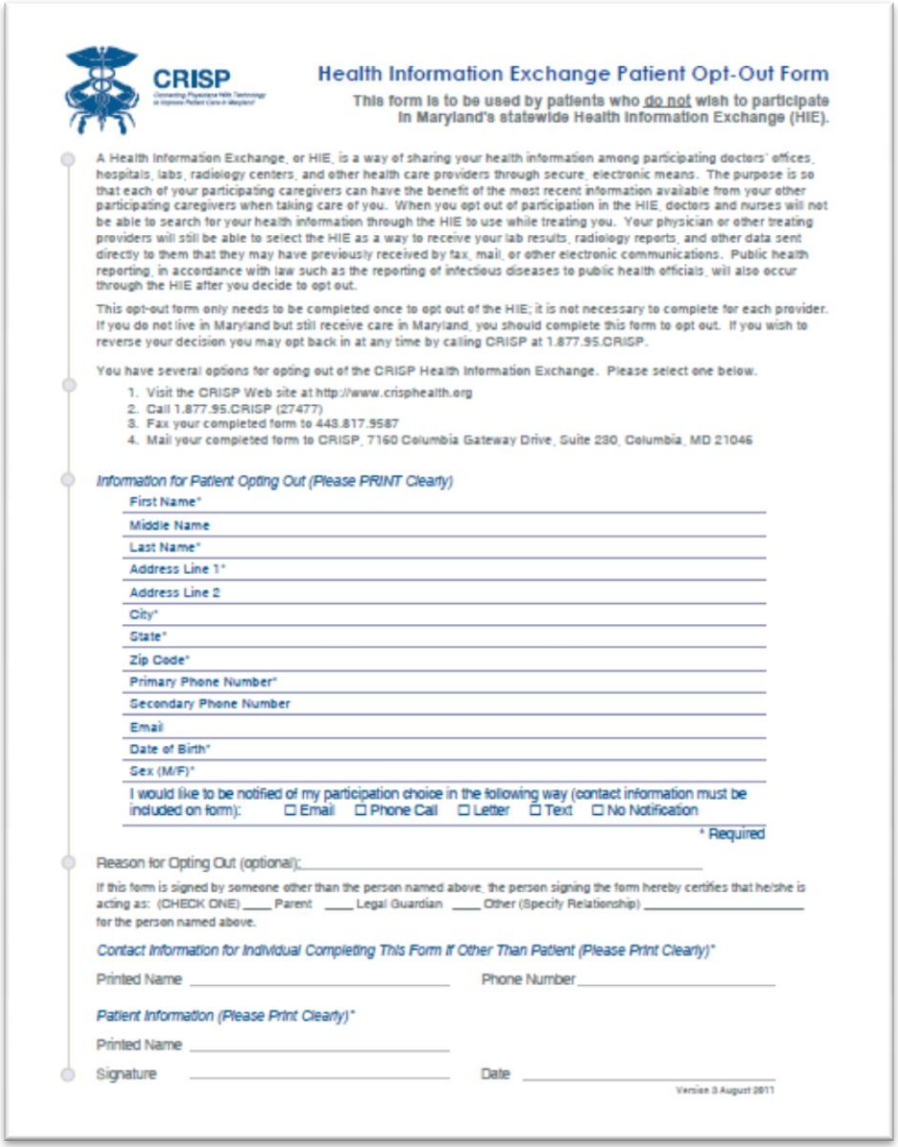
Rules of the Road

- Patient Privacy policies are foundational to Health Information Exchange
- CRISP operates under a combination of:
  - Federal laws – HIPAA, 42 CFR Part 2
  - State laws and regulations – CMRA, MHCC Regulations
  - Stakeholder agreements – Participation Agreement
  - Data use agreements – HSCRC, MHBE, DHMH
- All participating organizations are required to
  - Update their HIPAA Notice of Privacy Practices to include a paragraph on their participation with CRISP
  - Make CRISP brochures and opt-out forms available at intake areas.

- Patients who do not want to participate must opt-out, by contacting CRISP by phone, online, or by mail.
- Patients have the right to contact CRISP and ask for a list of users who have accessed their information.

Current Patient Awareness Approach

- All participating organizations are required to update their **HIPAA Notice of Privacy Practices** to include a paragraph on their participation with CRISP.
- All participating organizations are required to make **CRISP brochures** and **opt-out forms** available at intake areas.
- Patients are responsible for completing and **submitting the opt-out form to CRISP**. They may also opt-out by **phone** or **online**.



CRISP

Health Information Exchange Patient Opt-Out Form

This form is to be used by patients who do not wish to participate in Maryland's statewide Health Information Exchange (HIE).

A Health Information Exchange, or HIE, is a way of sharing your health information among participating doctors' offices, hospitals, labs, radiology centers, and other health care providers through secure, electronic means. The purpose is so that each of your participating caregivers can have the benefit of the most recent information available from your other participating caregivers when taking care of you. When you opt out of participation in the HIE, doctors and nurses will not be able to search for your health information through the HIE to use while treating you. Your physician or other treating providers will still be able to select the HIE as a way to receive your lab results, radiology reports, and other data sent directly to them that they may have previously received by fax, mail, or other electronic communications. Public health reporting, in accordance with law such as the reporting of infectious diseases to public health officials, will also occur through the HIE after you decide to opt out.

This opt-out form only needs to be completed once to opt out of the HIE; it is not necessary to complete for each provider. If you do not live in Maryland but still receive care in Maryland, you should complete this form to opt out. If you wish to reverse your decision you may opt back in at any time by calling CRISP at 1.877.95.CRISP.

You have several options for opting out of the CRISP Health Information Exchange. Please select one below.

1. Visit the CRISP Web site at http://www.crisphealth.org
2. Call 1.877.95.CRISP (27477)
3. Fax your completed form to 443.817.9587
4. Mail your completed form to CRISP, 7160 Columbia Gateway Drive, Suite 230, Columbia, MD 21046

Information for Patient Opting Out (Please PRINT Clearly)

First Name*
Middle Name
Last Name*
Address Line 1*
Address Line 2
City*
State*
Zip Code*
Primary Phone Number*
Secondary Phone Number
Email
Date of Birth*
Sex (M/F)*

I would like to be notified of my participation choice in the following way (contact information must be included on form): ☐ Email ☐ Phone Call ☐ Letter ☐ Text ☐ No Notification

* Required

Reason for Opting Out (optional): _____

If this form is signed by someone other than the person named above, the person signing the form hereby certifies that he/she is acting as: (CHECK ONE) ____ Parent ____ Legal Guardian ____ Other (Specify Relationship) _____ for the person named above.

*Contact Information for Individual Completing This Form If Other Than Patient (Please Print Clearly)**

Printed Name _____ Phone Number _____

*Patient Information (Please Print Clearly)**

Printed Name _____

Signature _____ Date _____

Version 3 August 2011

Agreements and Policies

CRISP

PREPARE FOR THE
FUTURE
of healthcare

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POLICIES AND APPROVED USE CASES

Approved Use Case - Cross-Facility Patient-Level Data Sharing Policy - Wednesday, September 23, 2015
Cross-Facility Patient-Level Data Sharing Policy. Effective September 23, 2015.

HIE Policies and Procedures - Thursday, April 17, 2014
CRISP HIE Policies and Procedures.

Approved Use Case - Access to Query Portal for Health Plans - Wednesday, December 10, 2014
HIE Policy for Health Plan Access to Query Portal. Effective December 10, 2014.

Approved Use Case - Reporting Service - Monday, June 4, 2012
HIE Policy for Reporting Service (CRS). Effective June 4, 2012.

Approved Use Case - Notification Service - Thursday, October 24, 2013
HIE Policy for Encounter Notification System (ENS). Effective October 24, 2013

Approved Use Case - Cancer Registry - Friday, September 7, 2012
HIE Policy for Cancer Registry Reporting. Effective September 7, 2012.

Approved Use Case - Query Portal Access Outside CRISP Service Area - Wednesday, September 11, 2013
Query Portal Access Outside CRISP Service Area. Effective September 11, 2013

Approved Use Case - CQM Reporting Tool - Thursday, May 14, 2015
HIE Policy for CQM Reporting Tool. Effective May 8, 2015.

PARTICIPATION AGREEMENTS

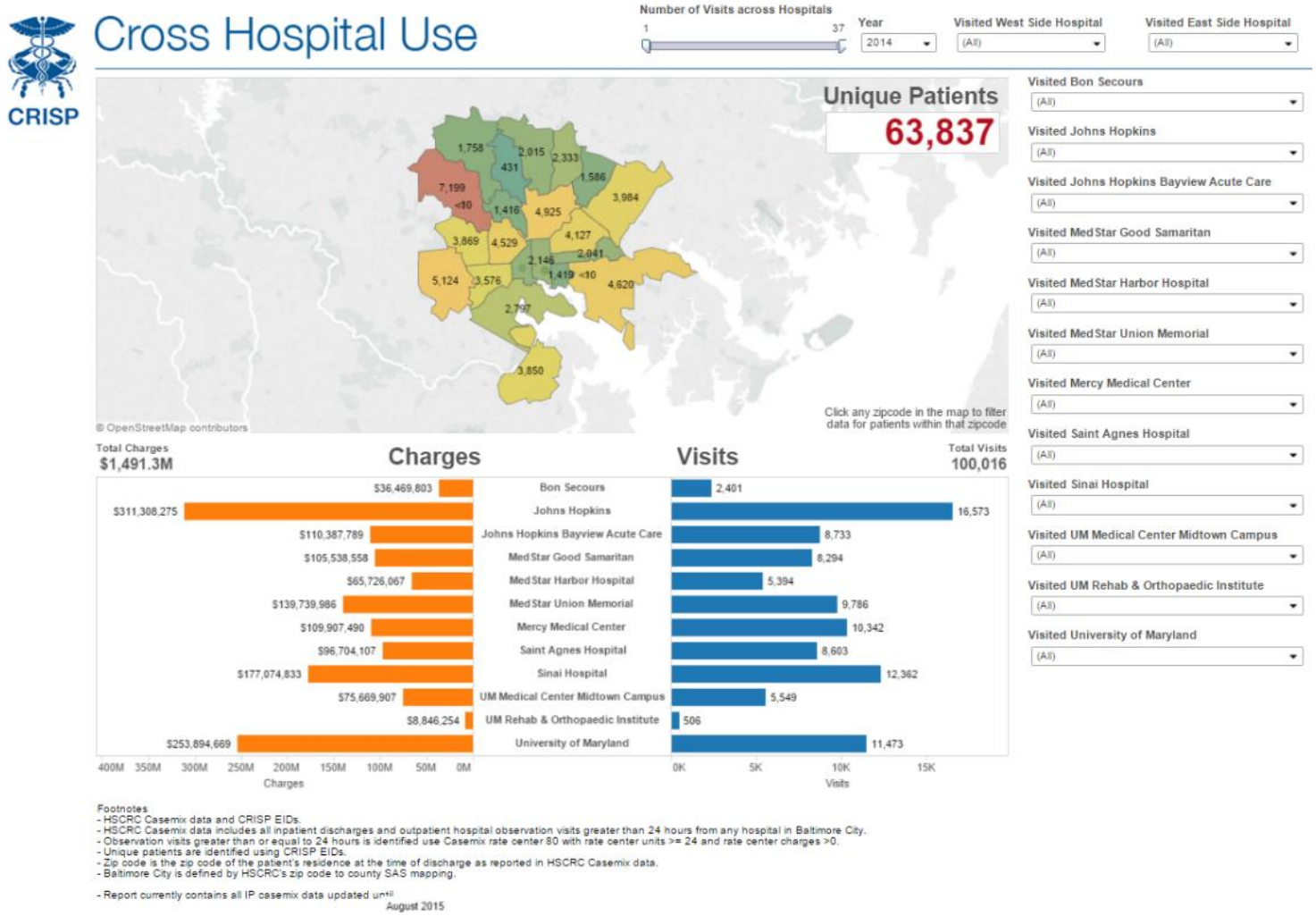
CRISP Participation and Direct Agreement - Wednesday, July 30, 2014
CRISP Participation and Direct Agreement.

ABOUT

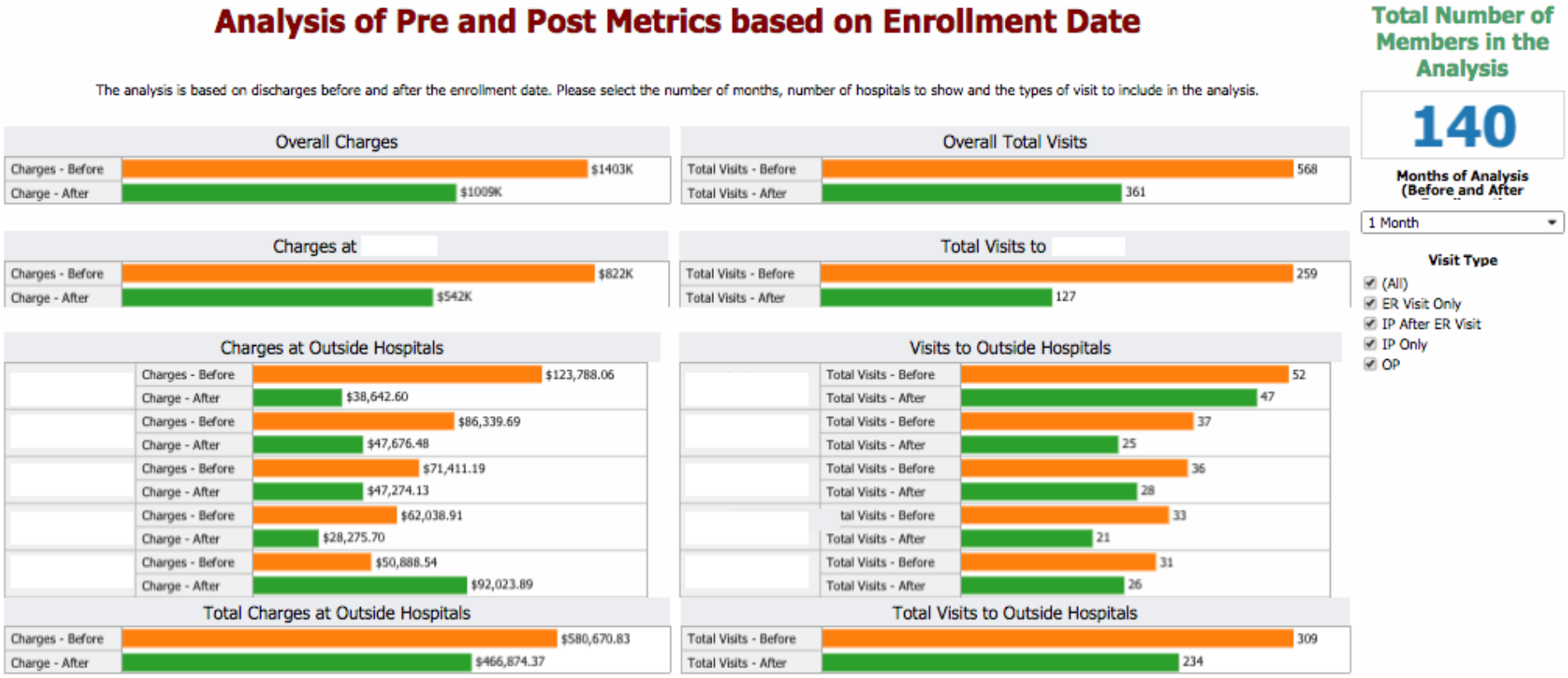
- General Info
- Governance and Leadership
- Management
- Policies & Agreements
- Contact Us

www.crisphealth.org

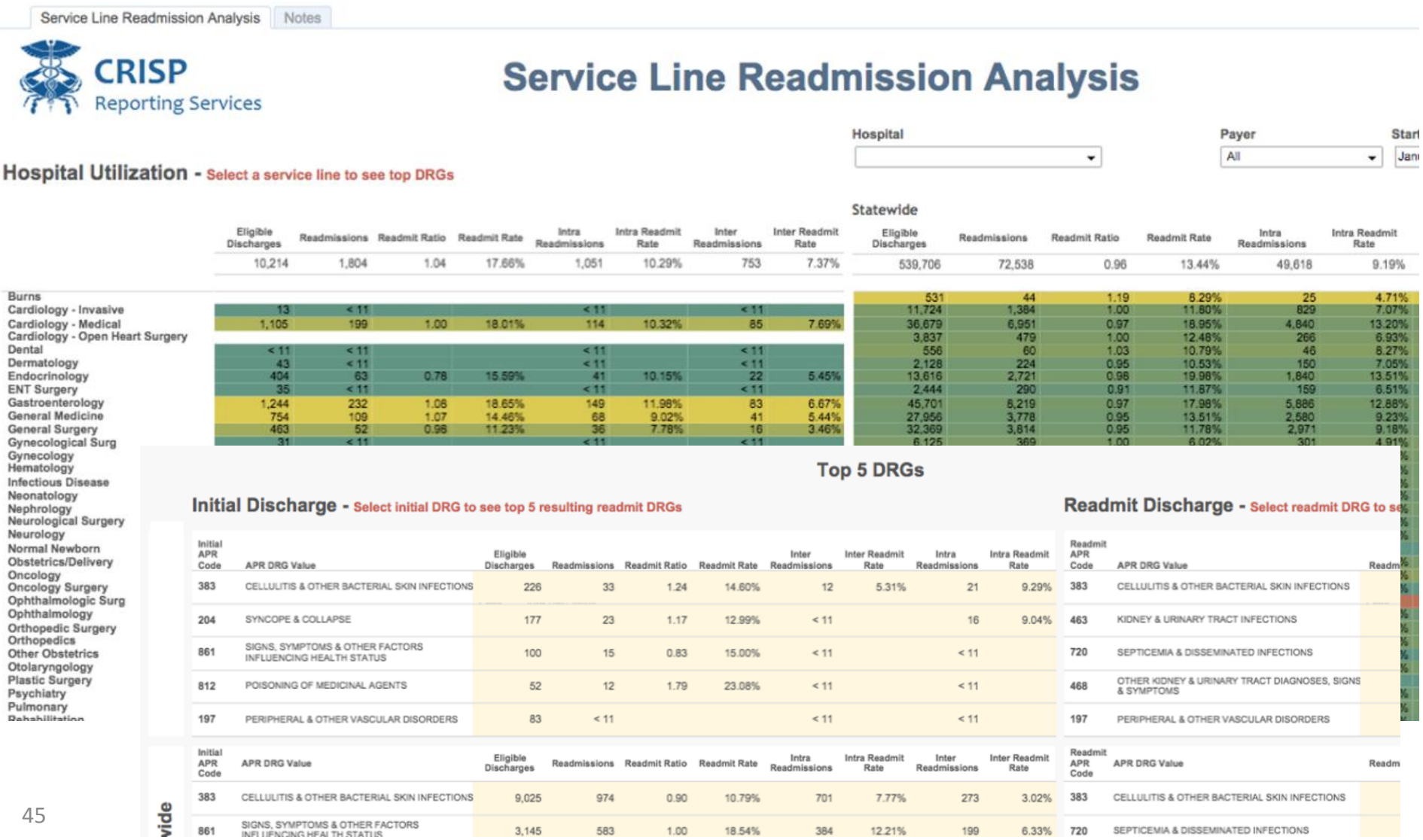
Regional Coordination and Planning



Pre / Post Intervention Analysis



Readmission Analysis



Service Line Readmission Analysis | Notes

CRISP Reporting Services

Service Line Readmission Analysis

Hospital | Payer | Start

All

Hospital Utilization - Select a service line to see top DRGs

	Eligible Discharges	Readmissions	Readmit Ratio	Readmit Rate	Intra Readmissions	Intra Readmit Rate	Inter Readmissions	Inter Readmit Rate
	10,214	1,804	1.04	17.66%	1,051	10.29%	753	7.37%
Burns								
Cardiology - Invasive	13	< 11			< 11		< 11	
Cardiology - Medical	1,105	199	1.00	18.01%	114	10.32%	85	7.69%
Cardiology - Open Heart Surgery								
Dental	< 11	< 11			< 11		< 11	
Dermatology	43	< 11			< 11		< 11	
Endocrinology	404	63	0.78	15.59%	41	10.15%	22	5.45%
ENT Surgery	35	< 11			< 11		< 11	
Gastroenterology	1,244	232	1.06	18.65%	149	11.98%	83	6.67%
General Medicine	754	109	1.07	14.46%	68	9.02%	41	5.44%
General Surgery	463	52	0.98	11.23%	36	7.78%	16	3.46%
Gynecological Surg	31	< 11			< 11		< 11	
Gynecology								
Hematology								
Infectious Disease								
Neonatology								
Nephrology								
Neurological Surgery								
Neurology								
Normal Newborn								
Obstetrics/Delivery								
Oncology								
Oncology Surgery								
Ophthalmologic Surg								
Ophthalmology								
Orthopedic Surgery								
Orthopedics								
Other Obstetrics								
Otolaryngology								
Plastic Surgery								
Psychiatry								
Pulmonary								
Rehabilitation								

Statewide

	Eligible Discharges	Readmissions	Readmit Ratio	Readmit Rate	Intra Readmissions	Intra Readmit Rate
	539,706	72,538	0.96	13.44%	49,618	9.19%
	531	44	1.19	8.29%	25	4.71%
	11,724	1,384	1.00	11.80%	829	7.07%
	36,679	6,951	0.97	18.95%	4,840	13.20%
	3,837	479	1.00	12.48%	266	6.93%
	556	60	1.03	10.79%	46	8.27%
	2,128	224	0.95	10.53%	150	7.05%
	13,616	2,721	0.98	19.98%	1,840	13.51%
	2,444	290	0.91	11.87%	159	6.51%
	45,701	8,219	0.97	17.98%	5,886	12.88%
	27,956	3,778	0.95	13.51%	2,580	9.23%
	32,369	3,814	0.95	11.78%	2,971	9.18%
	6,125	369	1.00	6.02%	301	4.91%

Top 5 DRGs

Initial Discharge - Select initial DRG to see top 5 resulting readmit DRGs

Initial APR Code	APR DRG Value	Eligible Discharges	Readmissions	Readmit Ratio	Readmit Rate	Inter Readmissions	Inter Readmit Rate	Intra Readmissions	Intra Readmit Rate
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	226	33	1.24	14.60%	12	5.31%	21	9.29%
204	SYNCOPE & COLLAPSE	177	23	1.17	12.99%	< 11		16	9.04%
861	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	100	15	0.83	15.00%	< 11		< 11	
812	POISONING OF MEDICINAL AGENTS	52	12	1.79	23.08%	< 11		< 11	
197	PERIPHERAL & OTHER VASCULAR DISORDERS	83	< 11			< 11		< 11	

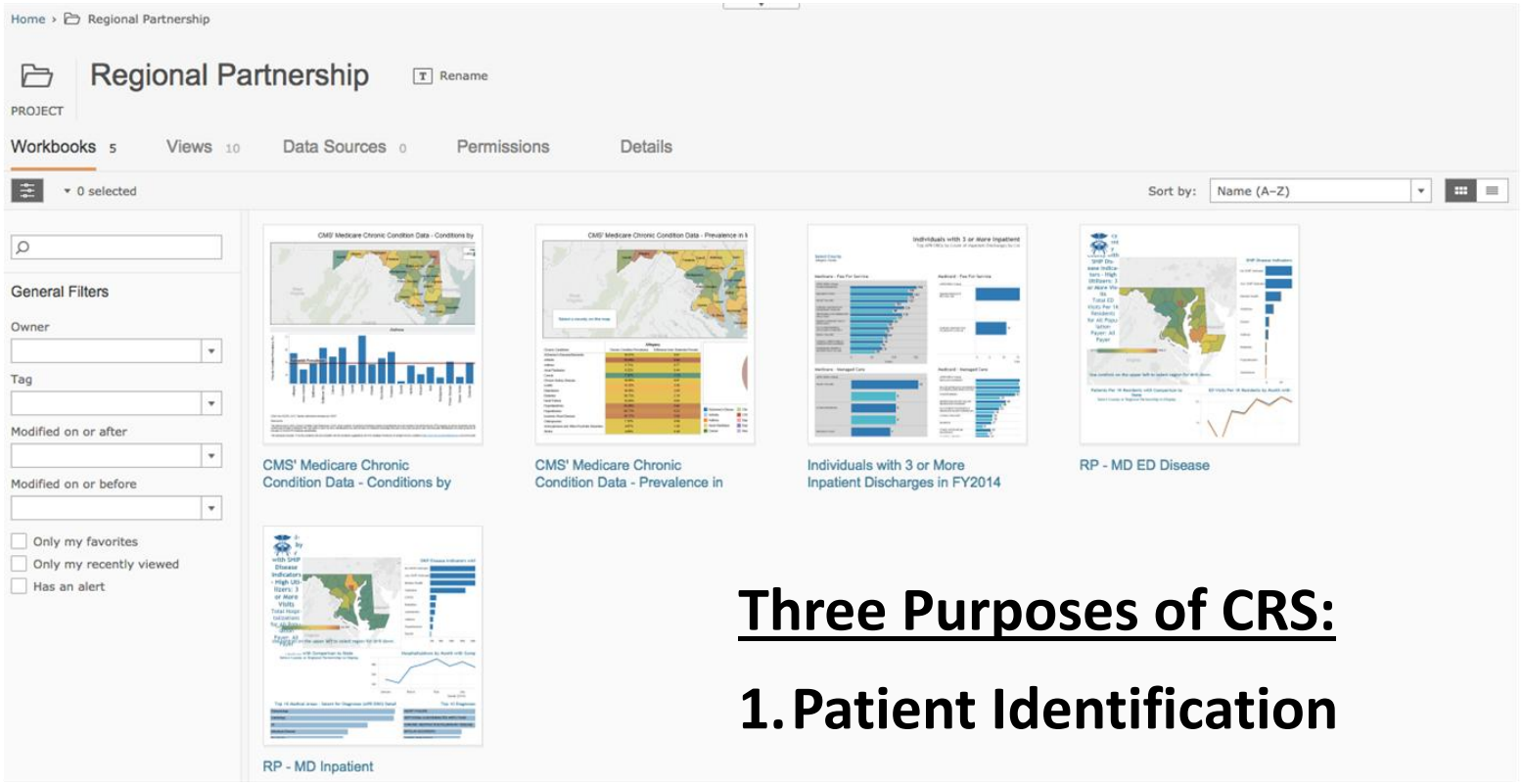
Readmit Discharge - Select readmit DRG to se

Readmit APR Code	APR DRG Value	Readm
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	
463	KIDNEY & URINARY TRACT INFECTIONS	
720	SEPTICEMIA & DISSEMINATED INFECTIONS	
468	OTHER KIDNEY & URINARY TRACT DIAGNOSES, SIGNS & SYMPTOMS	
197	PERIPHERAL & OTHER VASCULAR DISORDERS	

Initial APR Code	APR DRG Value	Eligible Discharges	Readmissions	Readmit Ratio	Readmit Rate	Intra Readmissions	Intra Readmit Rate	Inter Readmissions	Inter Readmit Rate
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	9,025	974	0.90	10.79%	701	7.77%	273	3.02%
861	SIGNS, SYMPTOMS & OTHER FACTORS INFLUENCING HEALTH STATUS	3,145	583	1.00	18.54%	384	12.21%	199	6.33%

Readmit APR Code	APR DRG Value	Readm
383	CELLULITIS & OTHER BACTERIAL SKIN INFECTIONS	
720	SEPTICEMIA & DISSEMINATED INFECTIONS	

CRISP Reporting Services (CRS)



<u>Three Purposes of CRS:</u>

1. **Patient Identification**
2. **Performance Measurement**
3. **Coordination of Services**

Upcoming CRS Reports

Patient Identification

- Risk stratification tools/methodologies applied
- Enhancements to Patient Total Hospitalizations reports
- Admission and discharge analysis

Performance Measurement

- Core metrics dashboard
- Panel-based trends and utilization reports
- Benchmarking for regions and providers

Coordination of Services

- Regional and cross-hospital patient utilization mapping
- Population-based Preventive Quality Indicator dashboards

Getting Started - Hospitals

- **Prior to providing individual user access, CRISP will work with the hospital to complete the following:**
  - **Review and sign the CRISP Participation Agreement**

  - **Established VPN and route outbound HL7v2 (ADT, Lab, Rad, Documents); CCD if possible**

  - **Validate CRISP developed interface**

  - **Update existing Notice of Privacy Practices to inform patients of the hospital's participation with CRISP and their right to opt out**

User On-Boarding

- **Visit http://onboarding.crisphealth.org. The registration process takes approximately 30 minutes. You may save your application at any time and return to it later.**
- Please have the following identifying information available:
  - An electronic copy of a government or employer ID
  - Personal (non-shared) email address
  - If applicable, license, DEA, NPI, and CDS numbers.

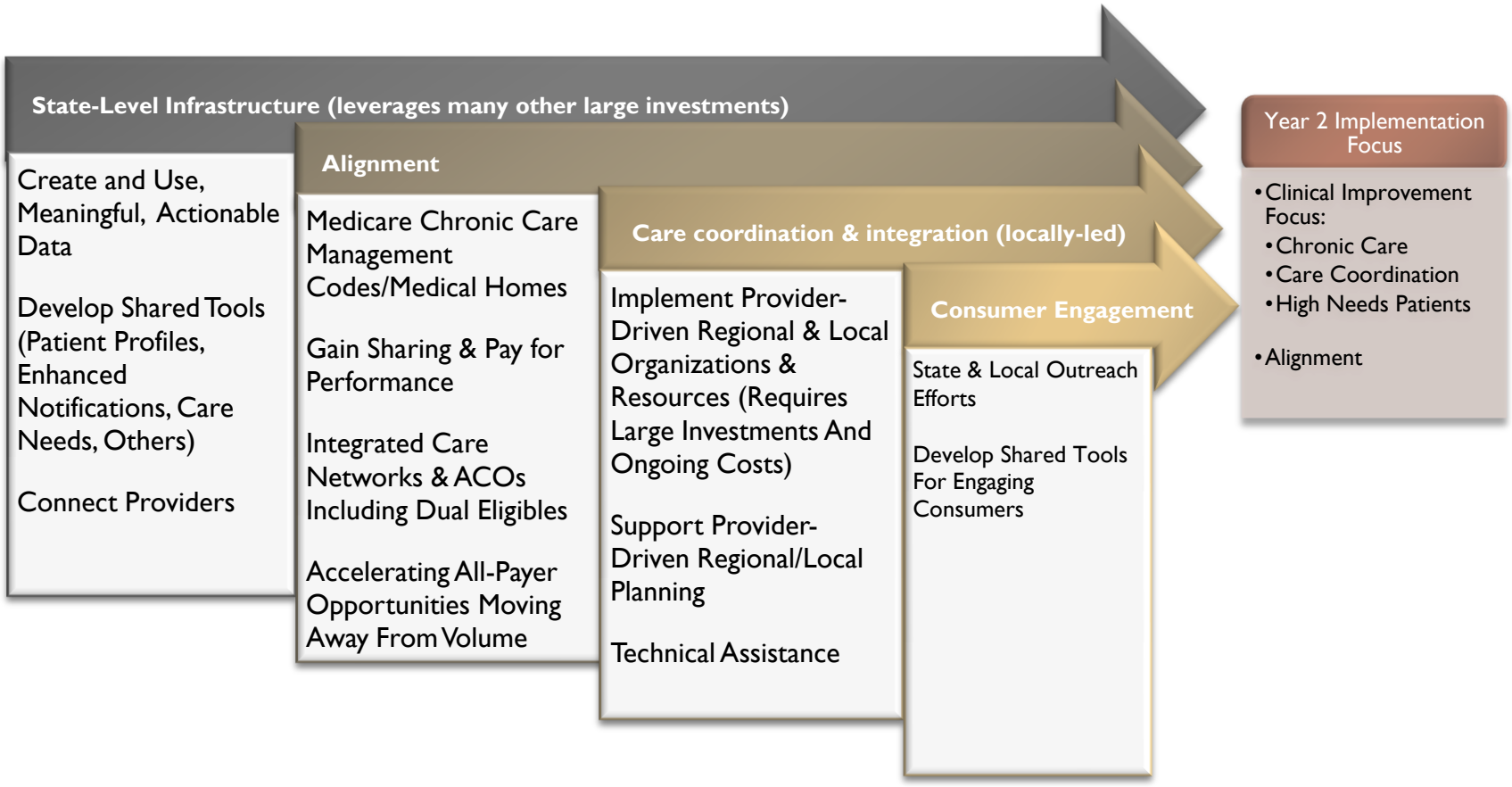
- **You will also need to complete the following steps:**
  - Sign PDMP Memorandum of Understanding
  - Watching CRISP Portal/PDMP training video
  - If obtaining access to clinical data, you will also need to be verified by organization Point of Contact

Integrated Care Network Infrastructure Project

Why:	The all-payer waiver and GBR will motivate new population-health efforts and care management initiatives…
And:	Stakeholders will need new infrastructures and access to data to support these activities…
It follows that:	Elements of these infrastructure could be shared, i.e. pursued cooperatively, both to avoid duplication of costs and to give care managers more complete data…
And if so:	CRISP was chartered and is governed to be the place where health IT solutions are deployed through cooperation and collaboration.

Maryland's Strategic Transformation Roadmap

Transform care delivery to support person centered care, coordinated across primary care, behavioral health, long term and other settings



From HSCRC presentation

ICN Project Organization

1. AMBULATORY CONNECTIVITY

The project aims to achieve bi-directional connectivity with ambulatory practices, long-term-care and, other health providers. Multiple methods of connectivity will be employed, including HL7 interfaces, CCDA exchange, and administrative networks.

2. DATA ROUTER

A key concept of the infrastructure effort is to send relevant patient-level data to the healthcare organizations who can use it for better care management. The data router will receive and normalize health records, determine a patient-provider relationship, verify patient consent, and forward the records where they should go in near real time.

3. CLINICAL PORTAL ENHANCEMENTS

The existing clinical query portal will be enhanced with new elements, including a care profile, a link to a provider directory, information on other known patient-provider relationships, and risk scores.

4. NOTIFICATION & ALERTING

New alerting tools will be built such that notification happens within the context of a provider's existing workflow. So for instance, if a patient who is part of a specific care management initiative shows up at the ER, an in-context alert could inform the clinicians that the patient has a care manager available.

5. REPORTING & ANALYTICS

Existing reporting capabilities, built on Tableau and Microsoft Reporting Services, will be expanding and made available to many more care managers. Will also plan for a potential new solution to support thousands of ambulatory practices.

6. BASIC CARE MANAGEMENT SOFTWARE

The current scope is for planning only, as the advisors help us determine an appropriate path.

7. PRACTICE TRANSFORMATION

The current scope is for planning only, as the advisors help us determine an appropriate path.

CRISP Governance

Board of Directors
Patty Brown, President Johns Hopkins Healthcare

Executive Committee
Mark Kelemen UMMS, Tricia Roddy DHMH, Adam Kane Erickson, Mark Schneider MedStar

Clinical Committee
Dr. Mark Kelemen, CMIO University of Maryland Medical System

Privacy & Security Committee
Mark Schneider, CIO MedStar

Analytics & Reporting Committee
Alicia Cunningham, VP Reimbursement UMMS

Finance Committee
Traci La Valle, VP Maryland Hospital Association

Technology Committee
Tressa Springmann, CIO LifeBridge

CRISP services are those best pursued through cooperation and collaboration. To make that possible 65 people participate in CRISP leadership through our governance committees.

Discussion

Questions?

SUMMARY AND NEXT STEPS

- Summary
  - Vision and goals of the project
  - All-Payer Model Overview
  - CRISP Overview
- Next steps
  - In-person Duals Care Delivery Workgroup Meeting
    - Monday, February 29—1:00-4:00
    - DHMH Room L-3
  - Full meeting schedule on next slide

DUALS CARE DELIVERY WORKGROUP MEETINGS

Meeting	Subject Matter and Goals
2) Feb 29	• Review, at high level, other states' approaches to duals' care coordination • Discuss existing MD infrastructure and ongoing projects touching dual eligibles, which may aid or limit options for a new program • Outline concepts and parameters for improving duals' care coordination
3) Apr 4	• Present and discuss refined vision for a duals care coordination program encompassing delivery organization, payment, quality concepts, and information infrastructure (include options that do and don't include hospital services affected by all-payer rate model)
4) May 2	• Present pre-final program concept reflecting feedback from Apr 4 meeting • Explain any waivers needed to implement program
5) Jun 1	• Present final program concept • Describe key elements of any waiver application
6) Jun 29	• Further discuss any waiver application